Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Wailua Ohana, Inc.	**CHAPTER 100.1**
Address: **187 Lihau Street, Kapaa, Hawaii 96746**	**Inspection Date: July 12, 2019 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Household member - No documentation of a two-step tuberculosis (TB) clearance. Single step TB skin test placed 6/12/19 and read 6/14/19.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Household member completed the 2-Step Tuberculosis (T.B) Clearance placed on June 10th 12. It was read on June 13th June 14. Obtained a copy from the physican on July 15, 2019.	8/4/19

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Licensee's/Administrator's Signature: Debra A. Bahnmiller

Print Name: Debra A. Bahnmiller

Date: Aug. 4, 2019

Licensee's/Administrator's Signature: Debra A. Bahnmiller

Print Name: Debra A. Bahnmiller

Date: Sept 1, 2019

Licensee's/Administrator's Signature: Debra A. Bahnmiller

Print Name: Debra A. Bahnmiller

Date: Oct 12, 2019